old to be bothered', 'worriers', 'fatalists' and 'avoiders'. Declining patients perceived they were at low risk compared to those taking part. Risk was believed to be related to family history and current health rather than smoking.

Conclusion Whilst screening methods in the Lung-SEARCH trial are largely acceptable to trial participants, strategies to increase acceptability and participation of this at-risk group should include providing tests locally, resolving anxieties concerning screening tests and addressing beliefs of those who underestimate or deny their risk of lung cancer.

P213 LONG TERM RESULTS OF CONCURRENT CHEMOTHERAPY AND HYPOFRACTIONATED RADIOTHERAPY FOR INOPERABLE NSCLC

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Concurrent chemoradiation is an effective form of treatment for inoperable stage 3 NSCLC, with a survival advantage in meta-analyses compared to standard chemotherapy and radiotherapy. However, reported local tumour control (LTC) rates are less than 40%. US studies aim to improve LTC by radiotherapy dose escalation and the addition of cetuximab. An alternative approach is to deliver radical radiotherapy concurrent with chemotherapy within a 4-week period, aiming to minimise the effects of accelerated repopulation and thus enhance LTC and survival.

We have treated 104 NSCLC patients with cisplatinum (30 patients) or cisplatinum and vinorelbine (74 patients) concurrently with 50–55Gy in 20 fractions over 26 days. Two-thirds of the patients were male, one third female; median age was 64. 90 patients had stage 3 NSCLC, 12 patients had inoperable stage 2 disease, and 2 had stage 4 disease. 84 patients were PS 0-1, 18 PS 2 and 2 PS 3. 64 patients received between two and four cycles of chemotherapy after completion of concurrent treatment.

Median survival for the whole group was 23 months. Survival rates at 3, 5 and 10 years (all causes mortality) were 41.7%, 30.1% and 16.2%. Chemotherapy after concurrent treatment increased median survival (26.6 vs 14.6 months) and survival at 2 years (53.1% vs 40%) but made no difference to survival at three and 5 years. There was an advantage for patients who received 55Gy compared to those who received 50–52.5Gy, with median survival of 37.9 months versus 20.6 months, 2-year survival 64.2% versus 40%, 3-year survival 56.2% versus 34.2% and 5-year survival 36% versus 28.5%. The local tumour control rate was 76% for patients receiving 55Gy and 68.6% for patients receiving 50–52.5 Gy.

There were no treatment related deaths. 86 patients developed grade 2 oesophagitis, nine patients suffered grade 3 oesophagitis and eight patients required dilation of oesophageal stricture between 8 weeks and 3 years after treatment.

Chemoradiation usingaccelerated hypofractionated radiotherapy concurrent with cisplatinum and vinorelbine enhances local control and survival for patients with locally advanced NSCLC and good performance status.

P214 PATHOLOGICAL STAGING OF MALIGNANT PLEURAL MESOTHELIOMA. HOW IMPORTANT IS NODAL DISEASE IN SELECTION FOR RADICAL SURGERY?

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Purpose Selection criteria for radical surgery in malignant pleural Mesothelioma (MPM) and related clinical trials remain controversial. The relative importance of nodal metastases and the need for preoperative nodal staging are undetermined.

Methods From a prospective database, we identified 203 patients (175 male and 28 female) with non-sarcomatoid MPM (Epithelioid 154 patients; Biphasic 49 patients). Preoperative staging included CT and mediastinoscopy. We investigated the effect of nodal burden and distribution on overall survival.

Results 125 patients underwent extrapleural pneumonectomy (EPP) and 78 radical pleurectomy/decortication (RPD) all with systematic nodal dissection. There was no difference in survival between EPP or RPD: 1 year 63% vs 56%; 3 year 17% vs 15% and 5 year 8% vs 5% p=0.55. The median number of lymph nodes resected was 10 (1–58); 88 (43%) patients were N0, 18 (9%) N1 and 97 (48%) N2. Patients with N0 disease had the best prognosis: median survival 22 months (SE 3, 95% CI 16 to 28) versus 11 months (SE 3, 95% CI 4 to 18) for N1 and 14 months (SE 1, 95% CI 11 to 17) for N2, p=0.005. There was no significant survival difference between N1 and N2, p=0.85. Overall survival was associated with the absolute number of positive extrapleural lymph nodes (p=0.05) and the number of extrapleural nodal stations involved (p=0.01) but not, the total (intra and extra pleural) number of involved nodes or stations (p=0.13 and 0.23).

Conclusions Extrapleural nodal status remains one of the most important prognostic factors following radical surgery for malignant pleural Mesothelioma. These data have important implications for preoperative staging and revision to the current IMIG staging system.

Abstract P214 Table 1 Actuarial survival following radical surgery

EPP + RPD n=203	1 year survival	2 years survival	3 years survival	4 years survival	5 years survival
pN0 n=88	70%	46%	23%	17%	15%
pN1 n=18	44%	22%	7%	–	–
pN2 n=97	55%	22%	10%	7%	–

P215 THE INFLUENCE OF AGE ON MANAGEMENT OF LUNG CANCER PATIENTS IN ENGLAND

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Introduction The evidence on which to base treatment decisions in the elderly patient with lung cancer is generally considered to be inadequate, with significant under-representation of older patients in key clinical trials. Although European recommendations have recently been published confirming the benefits of active treatment (EORTC Elderly Task Force), there are no UK guidelines and anecdotal evidence suggests that in the UK elderly patients have much lower rates of active treatment for lung cancer.

Methods Using the National Lung Cancer Audit dataset of 27 815 patients first seen in 2008, we have analysed a variety of measures according to patient age at the time of diagnosis. Patients outside the range 38–96 were excluded due to low numbers.

Results Comparison with Cancer Research-UK data shows that the elderly are not under-represented in the dataset; neither is there any evidence of under-reporting of key case-mix variables such as PS and Stage. Older patients tend to have lower stage at diagnosis, but this may be due to a reduced intensity of investigations. Not unexpectedly, there is a rapid decline in the proportion with good PS after age 70. Whilst FEV_1 (absolute) declines with age, the average FEV_1%